

Infidelity as a Cause of PTSD: "Much Overlooked" or Overdiagnosed? A Response to Dattilio (2004)

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In a comment on our recently published overview of cognitive-behavioral couple's treatment for posttraumatic stress disorder (CBCT for PTSD; Monson, Guthrie, & Stevens, 2003), Dattilio (2004) raised the concern that we had "omitted one of the most important and most difficult circumstances resulting in PTSD in couples: the trauma caused by extramarital affairs (EMA)" (p. 76). Our aims are to consider the issue of defining infidelity as a stressor precipitating PTSD and to address the role of infidelity within the context of our treatment. We use the word "infidelity," versus "extramarital affairs," to denote sexually unfaithful acts committed in any intimate relationship, regardless of marital status or sexual orientation.

Infidelity is a prevalent and pernicious problem for individuals, couples, families, and society in general. There is no doubt that the partner of an unfaithful individual can describe their experience as "traumatic," and that they may experience significant distress. However, infidelity does not meet the definition of a traumatic stressor for a PTSD diagnosis according to the *Diagnostic and Statistical Manual for Mental Disorders (DSM-IV-TR; APA, 2000)*.

The *DSM-IV-TR* indicates that a person has been exposed to a traumatic event if he or she "experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others" (p. 427), and responded with "intense fear, helplessness, or horror" (p. 428). Examples of traumatic events include combat, violent personal assault, disasters, accidents, and learning about the sudden, unexpected death of a family member or close friend.

Drawing from Glass's (2003) work, Dattilio (2004) writes, "many of the symptoms that follow the knowledge of infidelity may *mimic* [emphasis added] symptoms that are found with individuals who are exposed to a wide variety of stressors, such as

combat-related trauma or disaster situations" (pp. 76-77). Indeed, it seems wholly probable that partners of those having affairs might report fear, helplessness, and even horror, in reaction to disclosure or discovery of their partner's infidelity. Infidelity might even cause symptoms that resemble symptoms of PTSD, just as other psychosocial stressors can cause these types of PTSD-like symptoms. However, one has to stretch to describe most cases of infidelity as a threat to one's physical integrity or life, as required for a *DSM-IV-TR* PTSD diagnosis. Should a diagnosis of PTSD be given to an individual who is having distress because of suddenly and unexpectedly losing their job? Is it appropriate to give a diagnosis of PTSD to a husband who unexpectedly discovers that his wife is seeking a divorce and custody of their children? The ultimate question is whether these types of stressors reliably cause a reaction that is consistent with the phenomenology, symptom constellation, and biological findings of PTSD.

The available evidence indicates that the answer to this question is "no." In fact, this was one of the primary questions addressed in the *DSM-IV* field trials (Kilpatrick et al., 1998). The prevalence and phenomenology of symptoms caused by stressors excluded in previous editions of the *DSM* (e.g., marital conflict, job-related stress, simple bereavement) were investigated to determine if they produced PTSD. These stressors, by themselves, did not reliably yield a constellation of symptoms similar to those observed in individuals who experienced life-threatening and injury-producing situations. The *DSM-IV* (APA, 1994) stressor criteria were consequently not expanded to include such stressors. Moreover, there is substantial evidence that there are unique biological and psychological findings associated with PTSD versus other mental health conditions and stress reactions (Friedman, Charney, & Deutch, 1995). Until Dattilio (2004) or others can provide psychological and biological data to indicate otherwise,

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there is no reason to conclude that infidelity is a PTSD-inducing stressor.

Turning our attention to the implications of infidelity for CBCT for PTSD, we appreciate Dattilio (2004) highlighting an important contextual factor to be taken into account in the delivery of any couple's treatment. We do not agree, however, with his statement that "In most PTSD cases, one spouse becomes the healer, but in cases of infidelity, the spouse without PTSD is the offender" (p. 78). CBCT for PTSD is inherently systemic in nature, and our treatment is not designed in theory or practice to include an "Identified Patient" and partner "healer." We consider there to be multiple, reciprocally related individual and relationship factors that cause and maintain problems in both PTSD and relationship functioning, and usually in both members of the couple (see Monson, Stevens, & Schnurr, in press, for more elaborated theoretical discussion). Expanding on the latter point, we note in our original *BT* article that comorbid partner psychopathology is the rule rather than the exception. Thus, couple's interactions and both partner's thoughts, feelings, and behaviors are targeted in treatment.

Building on the bi-directional association between relationship distress and PTSD, and acknowledging the high rates of mental health disorders in both partners, CBCT for PTSD was not designed to be a partner-coaching or partner-facilitated treatment for PTSD. It is a disorder-specific couple's treatment designed to treat PTSD and relationship problems concurrently, in order to reduce relapse and facilitate further gains in both areas (see Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998, for discussion of different forms of couple's treatment). CBCT for PTSD was developed to have sufficient flexibility to address the myriad of couples' presentations in which one or both members of the couple has PTSD or other psychological problems.

Perhaps the most credible evidence of this couple's treatment approach is that the male veterans and their wives in our pilot study reported significant improvements in their individual symptomatology and relationship functioning (Monson, Schnurr, Stevens, & Guthrie, 2004; Monson et al., in press). Moreover, two of the seven couples had a history of unaddressed infidelity within the past 2 years, and over half of them had a history of experiencing infidelity in a previous intimate relationship. The infidelity-related issues were included as therapeutic content, and the cognitive themes introduced in the latter stage of CBCT for

PTSD (e.g., trust, power/control, intimacy) were well suited to the beliefs and feelings that developed in response to the infidelities.

Dattilio (2004) expresses concern that our focus on the emotions surrounding the memories, reminders and meaning of the traumatic events for the here and now "appears to contradict the specific work that is done in treating PTSD with couples when infidelity is the issue" (p. 77). He appears to have concern that we do not address the memories and reminders of events that trigger negative emotions. It is important that we disabuse him or other readers of the notion that we avoid traumatic material, as that would run in direct opposition to our cognitive-behavioral conceptualization of the role of avoidance in maintaining PTSD and relationship problems.

The important point to be made is that CBCT for PTSD does not involve partner-witnessed imaginal exposure entailing fine-grained descriptions of the traumatic events and related sensory experiences, thoughts, and feelings. This is to prevent possible secondary traumatization of the partners. Expanding this to infidelity, we assume that Dattilio, like us, would not be a proponent of graphic disclosures by the unfaithful partner about his or her affairs. However, we would certainly not collude in the avoidance of the unfaithful partner or the emotions and thoughts that surround the infidelity.

After improving the couple's communication skills, CBCT for PTSD focuses on modifying thoughts and beliefs held by both partners that maintain PTSD and relationship problems. These cognitions are related to the meaning that one makes about traumatic events and relationship interactions. Similarly, Dattilio (Dattilio & Padesky, 1990) notes in his book on cognitive therapy for couples that "The important task for a therapist when an affair is revealed is to discover the meaning this other relationship has for the individual having the affair and for the primary relationship" (p. 86). Thus, we are not entirely clear how our approach is inconsistent with other couple treatments that address infidelity.

Our comments are in no way meant to minimize the effects of infidelity. Infidelity, in and of itself, can lead to substantial individual and relationship distress that merits our best treatment efforts. Moreover, infidelity can contribute to the development or exacerbation of a variety of mental health diagnoses, including PTSD. In his conclusion, Dattilio (2004) intimates that political

issues might prevent the field from considering infidelity as a source of PTSD and from approving treatment plans that are equivalent in intensity and duration to any other treatment for PTSD. Undoubtedly, political forces are at play in the field. However, we question the management of these political issues by assigning a PTSD diagnosis to those with infidelity-related reactions. Doing so ignores the empirical evidence about the precipitants of PTSD and runs the risk of trivializing those who have biological and psychological responses consistent with the diagnosis of PTSD. Instead, we argue for greater research and educational efforts that educate insurance companies and government sponsored healthcare programs about the longer-term value of appropriate mental health treatment for its consumers. These efforts might diminish the tendency toward overdiagnosis and overreliance on medications as the frontline treatment. As researchers and therapists for couples, we are especially compelled to join in these efforts, given the lack of, or limited, funding for our interventions. Perhaps such advocacy would ultimately elevate the perceived gravity of relationship stressors, including infidelity, for the patients we treat.

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ACKNOWLEDGMENTS

This research was supported by grants to the first author from the Hitchcock Foundation at Dartmouth-Hitchcock Medical Center and the Department of Veterans Affairs Cooperative Studies Program. This material is also the result of work supported with resources and the use of facilities at the White River Junction VA Medical and Regional Office Center, White River Junction, VT.

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Persephanie Silverthorn, *Local Events Coordinator*

AABT comes to New Orleans for the second time in 4 years for its 38th Annual Convention. Those of you who were here for the 2000 convention remember our beautiful and vibrant city, but for those of you who have not been here or have not been here since the last convention, here are some interesting facts about New Orleans.

Tips for Travelers

(http://www.neworleanscvb.com/new_site/visitor/vistips.cfm)

Before you leave home, pack an umbrella, comfortable shoes, and a camera. Showers can arrive unexpectedly, and you want to make sure you are not caught by surprise. And you'll need a camera immediately.

The convention bureau recommends that you buy a VisiTour pass. Available in one-day or three-day denominations, the pass allows unlimited on-and-off privileges for the streetcars and buses. Great for exploring!

The CVB also recommends that you take a round-trip sightseeing tour on the St. Charles Avenue Streetcar. "It's a great way to get an overview of the Garden District, Uptown, and the University areas of town, and you'll be aboard a movable historic landmark. It's the oldest continuously operating street railway system in the world!"

Weather (based on 2000 U.S. Census Data)

In November:

Average High: 71

Average Low: 50

Average Precipitation: 4.5 inches

Annual precipitation: 61 inches

Annual number of clear days, no clouds: 109

Alcohol Laws

The drinking age in New Orleans is 21. Alcohol can be purchased on Sunday and in local beverage stores and supermarkets. There are no closing laws on how late a bar can stay open. Alcohol may be consumed in the streets of the French Quarter, but only in unbreakable containers.

Airport Information (www.flymsy.com)

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Airport Shuttle: Shuttle service is available from the airport to the hotels in the CBD for \$13.00 (per person, one-way), \$26.00 (per person, round-trip), or \$24.00 (per person, round-trip for two or more people when purchased at the airport). Three bags per person. Call 1-866-596-2699 or (504) 522-3500 for more details or to make a reservation. Advance reservations are required 48 hours prior to travel for all ADA accessible transfers. Please call well enough in advance for the specially equipped shuttle to be reserved. For group reservations of 10 or more people please dial 1-888-432-7651. Ticket booths are located on the lower level in the baggage claim area.

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